Mental Health Redesign and Implementation Task Force

Greater Milwaukee Foundation / Faye McBeath Foundation
Wednesday, December 5, 2012, 3:00 – 5:00 p.m.

Representatives: Barbara Beckert (DRW); Beth Burazin (Person-Centered Care AT & MHA); Pete Carlson (Task Force Co-Chair & Aurora Behavioral Health); Héctor Colón (DHHS); Peg DuBord (Continuum of Care AT & TLS); Kristina Finnel (Community Linkages AT & MHA); Pam Fleider (MC3); Rachel Forman (Grand Avenue Club); Mark Fossie (M&S Clinical Services); Susan Gadacz (BHD Community Services); Scott Gelzer (Workforce AT & Faye McBeath Foundation); Peter Hoeffel (Person-Centered Care AT & NAMI); Raisa Koltun (Milw. Co. Executive Staff); Henry Kunath (Quality AT & Phoenix Care Systems); Jon Lehrmann (MCW); Cheryl Lofton (State of WI); Paula Lucey (Task Force Co-Chair & BHD Administrator); Jim Mathy (Community Linkages AT & Housing Division Administrator); Leonor Rosas (Workforce AT & UMOS); Joy Tapper (Milw. Health Care Partnership); Joe Volk (Community Advocates); Peggy Romo West (Milw. Co. Board of Supervisors); Sally Winkelman (Proxy for Larry Pheifer, Medical Society of Milw. Co.)

Staff/Guests: Thomas Benziger; Serge Blasberg; Jennifer Collins; Martina Gollin-Graves; Patricia Goodwin; Monica Hogan; Bevelyn Johnson; David Johnson; Karen Johnson; Meg Kissinger; Jim Kubicek; Walter Laux; Jodi Mapp; Sue McKenzie; Candice Owley; Robin Pedersen; Ron Pupp; Patricia Rogers; Susan Sigl; Tonya Simpson; Chyra Trost; Beth Walloch

RISTAT: Chris Cline, MD (ZiaPartners); Andy Keller, PhD (TriWest Group); Ken Minkoff, MD (ZiaPartners); Jan Wilberg, PhD (Wilberg Community Planning, LLC)

Welcome & Introductions

Task Force Co-Chairs Paula Lucey and Pete Carlson and DHHS Director Héctor Colón welcomed full room of attendees and expressed thanks for ongoing partnership and progress toward improving services and increasing access and independence. Individual self-introductions, including welcoming Dr. Andrew Keller, a member of the technical assistance team, representing TriWest Group and assisting the Quality Action Team in the development of a community data dashboard. Agenda was reviewed, and minutes were approved for the October 31 meeting.

Redesign (Overall): Reporting on Progress & Challenges

DHHS ans BHD shared an informational report on the redesign to the Committee on Health and Human Needs, which considers the item at its December 12 meeting. The report included a spreadsheet proposed to serve as a plan and and inventory for redesign-related recommendations and actions through their various stages of completion. The spreadsheet is intended not as a definitive report, at present, but rather a living document to describe the work that has been done and to anticipate, clarify, and quantify the work that remains.

Ms. Lucey described various initiatives at BHD. The electronic medical record system went live on December 3 and should pave the way for numerous enhancements and efficiencies. Acute units are being further reconfigured from four units into three, effectively downsizing ten beds and redeploying resources from the closing unit. No further unit closure is anticipated, and all such measures are undertaken in collaboration with private hospitals to ensure no capacity shortages.

The report raised the issue of communications between various entities and workgroups within the redesign framework and the system as a whole. Kristina Finnel asked about possible

procedural improvements, such as formal motions and voting. The example given was how to create a new entity under the umbrella of redesign, such as a workgroup dedicated to funding issues, per the previous suggestion of Scott Gelzer. A dedicated funding group could tap into interest in the private philanthropic community for which the Task Force is not currently well positioned. A proposal for such a workgroup will be forthcoming at a future meeting. The regular meeting of BHD with hospital representatives was mentioned as a group that might communicate better with redesign stakeholders. It was clarified that that group is constituted as an operations improvement group focusing on transition care management, perhaps outside the scope of the redesign. The matter of mission and scope was held over to a later agenda item.

Action Team Reports

The Action Teams have reconvened and are continuing to do so. Each has developed a Scope of Work which will further discussions will move toward becoming *SMART* goals – specific, measurable, attainable, realistic, and time-bound. The Quality AT is operating differently and working with Andy Keller and TriWest Group to develop a community data dashboard.

Each Action Team presented its Scope of Work (attached at end of minutes). The Workforce AT was unsure of its present data needs but expressed a desire for membership from community employers, nonprofits, etc. Community Linkages AT expressed its focus on availability and utilization of supportive housing. Jon Lehrmann suggested Jacquline Bethany from the VA as a potential contributer to a discussion of supported employment. Ms. Lucey suggested engaging Families Moving Forward to support linkages with the faith community. Continuum of Care AT is eager to compile a system map and invites input from private providers to complement BHD participation. Person-Centered Care AT has welcomed many Change Agents from the MC3 initiative and emphasizes the need for authentic partnerships and clear communication. Advised the group to become more conscious in replacing the term "consumer" with "peer" or "person" wherever possible.

The Quality AT is pleased to involve Andy Keller from TriWest Group, bringing data to the forefront. The team is in need of more diverse representation, including persons with lived experience. Desire to "tag-team" the system mapping with the Continuum of Care AT; already laid some of the groundwork with TriWest and BHD staff prior to meeting. Hope to work with MC3 Evaluation Subcommittee as well.

Dr. Keller discussed the Scope of Work as well as a survey distributed in hard copy (to be sent electronically immediately following the meeting). Seeking three early wins: 1) draft a visual map, primarily focusing on the continuum through BHD but inclusive of other hospitals and contracted providers; 2) summary of volume (capacity) and use metrics from BHD services; and 3) additional guidance from as many stakeholders as possible on what data elements should be prioritized and represented on a dashboard (i.e. survey). Seeking survey responses by December 14.

Mission of Redesign

Discussion as to whether the redesign can or does deal with County-funded services or with the broader public-private system. Mostly about BHD services, but those services have significant impact on the broader community. Noted that an exclusive redesign of BHD, however, might not have necessitated or invited such diverse input – a true community effort involving public, private, and nonprofit sectors. Suggested that redesign should address "every program, every person, every dollar." An ongoing discussion, but many strong and valid points on the challenges and opportunities inherent in such a broad partnership and ambitious undertaking.

Meeting Close

Redesign Task Force to meet Wednesday, January 16, 3:00 to 5:00.

Attachment: Action Team Scopes of Work

Person-Centered Care

Goal 1: Empower people and their families across the board including persons with diverse ethnic backgrounds, diverse languages, and experiences as well as persons who have traditionally been unrepresented or underrepresented as full collaborative partners whose values and informed choices guide the provision of services and the evolution of the behavioral health system.

Objectives:

1.1 In preparing the Person-Centered Care action plan for the Mental Health Redesign, utilize the Comprehensive Continuous Integrated System of Care approach that incorporates mental health, substance use, physical health, and other complexities to create welcoming, accessible, integrated, and therapeutic environments.

1.2 Determine specific training needs for the community mental health system relative to person-centered, culturally-sensitive, trauma-informed, co-occurring competent care, informed choice, family engagement, Community Recovery Services, and Comprehensive Community Services.

1.3 Expand peer support and consumer-operated services to increase satisfaction, increase participation in services, and facilitate easier navigation between access points and levels of care.

1.4 Incorporate principles and standards of co-occurring competent, trauma-informed care and person-centered recovery into policies and procedures, RFP's, hiring and training processes, and service delivery at all levels and, including attention to health and substance use issues as well as mental health for all mental health providers and health care systems in Milwaukee County.

1.5 Promote respectful person-centered partnerships that celebrate wellness and see recovery as a reality and an expectation of care.

1.6 Reduce stigma among individuals, their families, and the broader community through education, outreach, and greater opportunities for persons with lived experience to tell their stories.

Goal 2: Improve access to prevention, early intervention, treatment, and recovery services through creative use of technology including social media, interactive technology, and other new, evidence-based approaches that improve access in an effective, non-stigmatizing manner.

Goal 3: Establish an accountability framework to ensure the incorporation of the principles of trauma-informed care and person-centered recovery in all components and all levels of the mental health system.

Objectives:

3.1 Develop/identify fidelity measures in trauma-informed care and person-centered recovery that can be used to monitor progress.

3.2 Join with the MC3 Evaluation Team to establish a system of monitoring and reporting progress on indicators.

3.3 Collaborate with the Quality Action Team and the Evaluation Subcommittee of MC3 to convene an entity comprised of consumers, advocacy agencies and other mental health stakeholders to ensure ongoing adherence to the principles of person-centered care and recovery.

Continuum of Care

Goal: Improve accessibility and flexibility along the continuum of care, enabling consumers to transition between types and levels of care in response to changing needs.

Objectives:

1.1 Develop a system to manage the flow of consumers through community-based services so the system becomes recovery-oriented, flexible and responsive to consumers' changing needs.

1.1.1 Develop metrics to show how this will expand the capacity and efficiency of resources.
1.1.2 Coordinate the development of the continuum of care with the continuum of housing and employment resources.
1.1.3 Evaluate the proposed continuum through the lens of the people using the services.

1.2 Integrate consumer-directed services and peer support into the above flow to assist consumers in system navigation and development of individual recovery plans.

1.3 Improve access to benefits counseling as a service that can be accessed by consumers in a variety of different locations, e.g. in mental health and substance abuse services, shelter system, housing, employment and other systems.

1.4 Expand and improve community-based services as part of the improved system flow as follows:
1.4.1 Expand community-based counseling and medication options for uninsured and underinsured consumers.
1.4.2 Improve the geographic diversity of service locations to ensure coverage in high-need areas of the community.

1.5 Advocate for the following (though not work directly on):
1.5.1 Support and expand mobile crisis services, collaborating with law enforcement and health care personnel with crisis training through the Crisis Intervention Team and Crisis Intervention Partner Programs.
1.5.2 Develop and expand alternative crisis services such as the Crisis Resource Center to enable diversions from unnecessary emergency treatment or hospitalization.
1.5.3 Expand small, short-term residential options to meet the most challenging behavioral needs of individuals with intellectual disabilities.
1.5.4 Expand of community-based rehabilitative services offered through Section 1937 of the Social Security Act (Community Recovery Services and Comprehensive Community Services).
1.5.5 Improve availability of a spectrum of community-based services for individuals with intellectual disabilities including crisis intervention, stabilization, respite capacity, and enrollment in Family Care.
1.5.6 Identification of alternative funding mechanisms to support the continuum of care.

Community Linkages

Goal 1: Increase the availability and appropriate utilization of recovery-oriented supportive housing.

Objectives:

1.1 Establish and meet an annual housing development goal (#units) that reflects a projection of need calculated based on the prior year's waiting list, SEWRPC Housing Study, BHD housing needs assessment, and other sources.

1.2 Explore a new housing model as a step-down from a CBRF to ensure individuals can live in the least restrictive setting even if not ready or able to live in permanent supportive housing.

1.3 Downsize approximately 10% of the County's contracted CBRF beds by filling vacant County-contracted beds with Family Care enrollees and increasing access to recovery-oriented housing options.

1.4 Develop a strategy to manage the supportive housing utilization and flow including consideration of level of care criteria and mechanisms for facilitating continuity; develop metrics to show how this will expand the capacity and efficiency of resources.

Goal 2: Increase the availability and appropriate utilization of support employment and increase the number of consumers employed.

Objectives:

2.1 Promote employment and access to employment services for individuals with severe and persistent mental illness including strategies to utilize IPS (Individual Placement and Support) and other employment models.
2.2 Develop benchmarking tools including a) baseline of consumers who are employed or who want to be employed; and b) continuum of currently available employment services and opportunities.

Goal 3: Mobilize community systems and resources to support diversion from unnecessary emergency treatment and hospitalization, improve discharge planning, and promote recovery.

Objectives:

3.1 Establish an information-sharing agreement (data link) between the Behavioral Health Division, Milwaukee County criminal justice system, and the Milwaukee Continuum of Care (emergency shelters) to enable shelters and criminal justice staff to ascertain whether a consumer has a service/case management relationship with a provider and coordinate with that provider to improve outcomes for the consumer.
3.2 Develop a plan for the role of the Intervention Specialist to serve as the liaison between various public and private entities commonly interacting with individuals in the community with the most complex needs.

Workforce

Goal 1: Improve the cultural competence and person-centered, recovery-oriented, trauma informed, co-occurring competent clinical skills of the system's workforce.

Objectives:

1.1 Develop a set of core competencies in person-centered, co-occurring, recovery-oriented, culturally competent care for all staff in the system; and develop a plan for the use of these competencies in recruitment, hiring, retention, and ongoing training efforts.
1.2 Insure that the workforce is reflective of, and sensitive to, the consumer population beginning with recruitment, hiring, and retention and including timely access to interpreter and translators with proficiencies in person-centered and trauma-informed care.
1.3 Partner with higher education to improve preparation of nurse practitioners, nursing aides, social workers, psychologists, psychiatrists, and advance practice nurses; and to promote behavioral health as a career path, prepare licensed professionals for interdisciplinary teams, provide clinical experience to students, and update curricula to align with person-centered and recovery principles and evidence-based practices.

Goal 2: Improve recruitment and retention of qualified practitioners.

Objectives:

2.1 Strive to make public sector entities competitive with the private sector in terms of compensation and retention incentives to ensure consistently high quality services throughout the system.
2.2 Address the certification and credentialing requirements of the Affordable Care Act as pertains to behavioral health providers in Milwaukee County, specifically addressing requirements for Medicaid reimbursement.

Goal 3: Expand utilization of Certified Peer Specialists throughout the system.

Objectives:

3.1 Establish a dashboard to inventory and monitor the number of Certified Peer Specialists, place of employment, and other key metrics; document the need for Certified Peer Specialists (CPS) over the next five years.
3.2 Develop a plan to document the impact of CPS on the people being served.

3.3 Expand CPS training and certification programs to meet anticipated demand.
3.4 Develop a plan to ensure consistency and high quality in the delivery of CPS services through continuing education and evaluation.
3.5 Develop a plan to upgrade compensation and retention incentives to align with CPS' role in the system.
3.6 Educate current and potential employers of CPS regarding roles and responsibilities.

Quality

Goal 1: Strengthen the membership of the Quality Action Team / QA/QI Committee.

Objectives:

1.1 Recruit membership with Lived Experience;
1.2 Recuit membership with more Diverse Demographic Representation;
1.3 Recruit membership with greater Action Team cross-over;

Goal 2: Develop a Map of the Entire System Resource Categories from Least Independent to Most Independent.

Goal 3: Develop a dashboard including outcomes and indicators at each level with the System Map.

Goal 4: Develop a Web-based Repository Accessible by the Redesign Task Force Membership to Store the Dashboard & Action Team Work in Progress (WIP)